**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name and Address**

LESHA ROBERTS DC
ASHFORD CHIROPRACTIC
1710 DAIRY ASHFORD #109
HOUSTON TX 77077

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

**Respondent Name**
TEXAS MUTUAL INSURANCE CO

**Carrier's Austin Representative Box**
Box Number 54

**MFDR Tracking Number**
M4-10-4956-01

**MFDR Date Received**
JULY 29, 2010

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary as stated on the Table of Disputed Services:** "Provided services was denied for no Pre-Auth. Pre Auth not required for services rendered. Per TDI. See attached letter."

**Amount in Dispute:** $160.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "…Texas Mutual audit staff received the billing and associated documentation, reviewed the pertinent preauthorization approval letter, reviewed prior billing of code 98940/98941 by the requestor, reviewed the ODG relevant guideline, then denied payment of code 98940 as it required preauthorization. The authority to do so was derived from DWC Rule 134.600 at (p)(12) which states, …Non-emergency health care requiring preauthorization includes…treatments and services that exceed or are not addressed by the Commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the carrier.. The requestor has included a letter from System Monitoring & Oversight (SMO) to support its assertion that preauthorization of code 98940-98941, manipulations, is not required. Texas Mutual does not agree with the conclusion reaching by SMO and believes that conclusion is inconsistent with and contrary to Chapter 413.011(e) of the Labor Code and its own Rule 134.600."

**Response Submitted by:** Texas Mutual Insurance Co., 6210 E. Hwy 290, Austin, TX 78723

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| August 10, 2009, August 12, 2009, August 17, 2009 August 19, 2009 | CPT Code 98940 | $160.00 | $147.65 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.600 sets out the procedures for obtaining preauthorization.
3. 28 Texas Administrative Code §134.203 sets out the guidelines for reimbursement for professional services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 197 – Precertification/Authorization/Notification Absent.
   - 930 – Pre-authorization required, reimbursement denied.
   - W4 – No additional reimbursement allowed after review of appeal/reconsideration.
   - 891 – The insurance company is reducing or denying payment after reconsideration.

**Issues**

1. Do chiropractic manipulations, CPT Code 98940, require preauthorization?
2. Is the requestor entitled to reimbursement?

**Findings**

1. The carrier denied services using denial code 197 – "Precertification/Authorization/Notification Absent" and 930 – "Pre-authorization required, reimbursement denied." In accordance with 28 Texas Administrative Code §134.600(p) chiropractic manipulations are not one of the treatments/services that require preauthorization. The above denial reasons is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. Review of the submitted documentation finds that the treatment was rendered as billed. Therefore, in accordance with 28 Texas Administrative Code 134.203(b) reimbursement is recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $147.65.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $147.65 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | April 10, 2013<br>Date |
|---|---|---|

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.